Connecticut Elder Action Network (CEAN)

A dynamic network of leaders advancing responsible public policy

2004 LEGISLATIVE SUMMARY

Aging Issues

June '04

Executive Committee
CT Commission on Aging, Chair
AARP – CT
Center for Medicare Advocacy Inc.
CT Association of Area Agencies on Aging
CT Coalition on Aging
CT Community Care, Inc.
CT Council of Senior Citizens, Inc.
CT Association of Municipal Agents for the Elderly
CT Association of Senior Center Personnel

Connecticut Elder Action Network (CEAN) - Brief Background

In response to requests from legislators that older adults and their advocates do their best to speak with a common voice, stakeholders throughout Connecticut came together to form a working advocacy group whose main goal was to develop and pursue a well-supported short list of legislative priorities. This effort, which has become known as the Connecticut Elder Action Network (CEAN), has involved a dynamic group of leaders working together to advance responsible public policy for elders. Its Executive Committee members include: the Connecticut Commission on Aging, AARP-CT, the Center for Medicare Advocacy, Inc., the Connecticut Association of Area Agencies on Aging, the Connecticut Coalition on Aging, the Connecticut Council of Senior Citizens, Inc., the Connecticut Association of Municipal Agents for the Elderly, the Connecticut Association of Senior Center Personnel, and Connecticut Community Care, Inc.

CEAN 2004 Priority Statements

During the 2004 session, CEAN developed and promoted priority statements in three principal areas:

- **Access to Prescription Drugs**
- **Access to Home and Community-Based Supports**
- **Access to Information and Services**

Primary rationales for selection of these three areas were:

1) that pharmaceutical drugs, costs for which are prohibitively expensive for those elders without a source of financial assistance, are a critical element of community-based long-term care;
2) that the capacity of the long-term care system to respond to the needs of the burgeoning elder population is a critical matter that will affect all of us – individuals, families, government and society as a whole; and
3) that access to timely, neutral and consumer-friendly information on services and supports is an essential part of planning ahead for the needs of older adults and their caregivers.

Results of the 2004 Session

I. Access to Prescription Drugs

- **CEAN Priority Statement**: Ensure that ConnPACE remains valuable and accessible during the implementation of the Medicare Prescription Drug Programs.
  Wrap-Around Benefit

  During the 2004 session, the Legislature and Administration resolved how the state-funded ConnPACE program will interact with the new Medicare prescription drug discount cards. In doing so, policymakers sought both to maximize use of federal benefits for all low-income beneficiaries and to tailor how the ConnPACE subsidy will interact with the federal benefit.

  Public Act 04-6:

  a) notes 2004 ConnPACE income eligibility limits of $20,800 for an individual and $28,100 for a couple; further, establishes that a Medicare discount prescription drug card will be considered an exception when determining whether an individual has other available full or partial prescription drug coverage
  b) establishes that an individual who holds a Medicare discount prescription drug card will be obligated to pay the required coinsurance under that coverage only to the extent that the coinsurance does not exceed the ConnPACE coinsurance amount (currently, $16.25 per prescription); further, establishes that DSS will reimburse pharmacies to the extent that an individual's Medicare coinsurance amount exceeds the ConnPACE coinsurance amount
  c) requires all individuals whose income is less than or equal to 135% of the Federal Poverty Level to obtain a Medicare prescription drug discount card as a requirement of participating in ConnPACE; further, permits DSS to require this of individuals whose income exceeds 135% of the FPL if it is determined that will be cost-effective for the State (should this option be pursued, would permit DSS to cover any applicable discount card enrollment fees)

  Close on the heels of passage of P.A. 04-6, **Public Act 04-101** amended certain of its provisions, providing that ConnPACE participants who are required to obtain Medicare prescription drug discount cards must re-apply for them on an annual basis, that participants will be given the opportunity to select an endorsed Medicare card, and that if a participant fails to do so, the DSS Commissioner is authorized to do so on their behalf.

  Medicare Prescription Drug Discount Card Background

  The Medicare Prescription Drug Discount Card Program will operate from June, 2004 through December, 2005. For certain low-income individuals, the cards come associated with a $600 annual Transitional Assistance (TA) benefit. Authorized by the Medicare Improvement and Modernization Act of 2003, the discount cards are the initial effort to provide some assistance with the costs of prescription drugs.

  To date, the Centers for Medicare and Medicaid Services (CMS) has approved 73 general purpose cards, 40 of which are being offered nationwide and 33 of which are regional. Additionally, CMS has approved 84 cards exclusively for use of enrollees of Medicare HMO's.

Initially, DSS announced that ConnPACE would select only a certain number of endorsed cards for use by ConnPACE participants who are now required to do so. This, however, caused serious concern that a ConnPACE participant who elected to use a particular, endorsed discount card could experience restrictions in accessing needed drugs due to limited or changing formularies associated with particular cards. DSS did respond to this issue by later announcing that ConnPACE participants are permitted to elect any of the available card offerings without limitation.

There remains ongoing concern, however, that where an individual selects a given card, it will not be accepted at a pharmacy local to the individual in question, an access barrier for those who are homebound and rely on home delivery or local transportation services to fill their prescriptions. Further, initial experience with the cards has left many participants confused and uncertain, as information on drug prices available through the CMS website does not always correspond to actual experience at pharmacies. Finally, there remain inconsistencies as certain pharmacies that have been listed as participating have refused to accept the cards on a local basis.

- **CEAN Priority Statement:** Ensure that co-payments take into account the low-income status of participants by:

  - restoring ConnPACE co-payments to 2003 levels ($12/per prescription drug).
  - eliminating Medicaid prescription drug co-payments.

ConnPACE Co-Payments Remain Unchanged

Participants of the ConnPACE program remain obligated to make a co-payment of $16.25 per prescription.

ConnPACE Co-Payment Background

Section 14 of P.A. 03-2, which was effective upon passage on February 28, 2003:

1) increased co-payments from $12 to **$16.25** per prescription for single participants with incomes less than $20,300 and married participants with incomes less than $27,500;
2) conditional on approval of the ConnPACE waiver request (still pending with the Centers for Medicare and Medicaid Services), authorized a further increase in co-payments to **$20** for single participants with incomes greater than or equal to $20,300 and married participants with incomes greater than or equal to $27,500; and
3) increased the annual registration fee from $25 to **$30**.

Medicaid Co-Payment Repeal

Section 9 of Public Act 04-258 eliminates the $1.50 prescription co-payment for individuals who receive State Administered General Assistance (SAGA) medical assistance, but also institutes a three-month look-back period for transfers (look-back renders applicant ineligible for SAGA medical assistance if he or she assigns, transfers, or otherwise disposes of property for less than fair market value during the three months prior to application) – effective July 1, 2004.

Section 43 of Public Act 04-258 repeals Section 72 of P.A. 03-3, which required Medicaid recipients to make co-payments of $1.50 for each prescription and $3.00 for each outpatient medical service; further, repeals Section 69 of P.A. 03-3, which required that DSS seek federal approval to allow pharmacies to refuse to fill prescriptions for Medicaid recipients who have chronically been unable to make required co-payments – effective July 1, 2004.

Co-Payment Background

The Legislature first obligated participants of the SAGA and Medicaid programs to make co-payments for prescription drugs and outpatient medical services in 2002. The amount due for each prescription drug fill was then increased from $1.00 to $1.50 by Public Act 03-3. One of the Governor's '04 budget bills (House Bill 5041) sought to establish 1) up to a $3 co-payment for each Medicaid outpatient service; 2) a $1.50 co-payment for each Medicaid prescription; and 3) a $2 co-payment for each non-emergency ride for those not enrolled in a managed care plan. Due to strong opposition, however, these expanded co-payment obligations were not enacted into law in the 2004 session. Separately, several sections of Public Act 03-3 (the 2003 DSS "implementer") authorized efforts to make existing co-payment obligations more restrictive. **Section 69** required DSS to seek a waiver of federal Medicaid requirements such that pharmacists would be authorized to refuse to fill prescriptions for Medicaid recipients where there was "documented and continuous failure to make required co-pays, notwithstanding having the financial ability to do so". "Continuous failure" was defined as 1) failure to make a co-payment within 6 months of receiving the drug; or 2) failure to make 6 or more co-payments for prescriptions that are filled in any 6-month period. This section made an exception for psychotropic drugs. As noted above, authorization to seek this waiver was repealed in the 2004 session.

Throughout 2003, existing pharmacy co-payment obligations proved to be a substantial barrier for older adults and others seeking to have their prescriptions filled. Although federal law provides that pharmacists and other health care providers may not refuse to provide service if any individual is unable to make the co-payment, and must accept that individual's statement to this effect, many older adults felt obligated to come up with the means to do so, either on their own or with help from their home care or other service providers. Where there was no alternative to non-payment, pharmacists maintained records of accruing, unpaid co-payments that often amounted to a substantial "debt" in the perception of those filling the prescriptions.

Of ongoing concern is that individuals who become eligible for the new Medicare Part D prescription drug benefit (effective 2006) may be subject to further cost-sharing requirements. Connecticut may be able to improve the federal Medicare prescription benefit for those eligible for both Medicaid and Medicare, but it will have to do so exclusively with State, not federal, funds. Hopefully some of the savings to the State that are estimated to derive from implementation of the Medicare drug benefit will be used for this purpose. This will likely be an advocacy issue for 2005-2006.

- **CEAN Priority Statement**: Preserve and expand eligibility for ConnPACE by repealing the estate recovery and the asset test requirements enacted in 2003.

Estate Recovery Repeal

Section 11 of Public Act 04-258 (the DSS "implementer") repeals the ConnPACE estate recovery provision that was enacted as Section 59 of P.A. 03-3 – effective on passage (May 21, 2004).

Estate Recovery Background

ConnPACE is one of a limited number of state-funded programs that has not historically been subject to an estate recovery provision. Through estate recovery, the State recoups funds expended during a recipient's lifetime from any assets that remain at the time of his or her death.

With twin goals of 1) making the ConnPACE program conform to other state programs; and 2) potentially yielding additional revenue for the program, the Legislature in 2003 enacted Section 59 of P.A. 03-3 (the DSS "implementer"), which imposed recovery provisions on the estates of ConnPACE recipients whose deaths occurred on or after September 1, 2003. Claims were to apply retroactively to benefits received on or after July 1, 2003. Immediately after the Department of Social Services announced this new program requirement to participants, however, a substantial number opted out of the program rather than be subject to estate recovery. Further, the CHOICES programs and others noted that many elders were chilled from initial enrollment in the program primarily because of estate recovery requirements.

As a result of these concerns, the Governor announced mid-year his intention to suspend estate recovery efforts and directed DSS not to go forward with them. Section 11 of P.A. 03-3 repeals the statutory authority for estate recovery enacted in 2003.

Asset Test Repeal

Section 12 of Public Act 04-258 repeals the ConnPACE asset limit of $100,000 for an individual and $125,000 for a couple that was enacted as Section 58 of P.A. 03-3 – effective upon passage (May 21, 2004)

Asset Test Background

Section 58 of Public Act 03-3, effective October 1, 2003, limited eligibility for the ConnPACE program to those individuals with available assets below $100,000, and those couples with available assets below $125,000. Available assets were defined as those considered for eligibility for the Home Care Program for Elders (example: home not considered an available asset).

Since it was first enacted in 1986, ConnPACE eligibility has been based solely on income. This parallels the guidelines for pharmaceutical assistance in other states, none of which require an asset test. Originally proposed as part of the Governor's budget measures, Connecticut's asset test was enacted as part of the 2003 DSS "implementer"

bill. In response, advocates expressed concern that the asset test would hurt those who depend on the modest income generated by their savings to pay for food, housing and medical care during retirement. It was further commented that those without pensions to supplement their Social Security income, and recipients of lump-sum reverse annuity mortgage payments would be adversely affected by this policy. Advocates feared that the asset test would lead to disqualification of a substantial number of current enrollees, as well as self-selection in the application and annual renewal processes. This was borne out by DSS's action in sending letters noting that the asset test has been repealed to approximately 6,100 disenrolled ConnPACE participants.

- **CEAN Priority Statement:** Review implementation of the prior authorization system to determine impact on participant access to needed drugs.

No Action on Prior Authorization

The Legislature took no action on prior authorization in the 2004 session.

Prior Authorization Background

On July 16th, 2003, DSS implemented a prior authorization requirement for all fills of prescription drugs under the Medicaid, ConnPACE and SAGA programs. This means that advance approval must be sought to fill 1) brand-name drugs with generic equivalents; 2) prescriptions for drugs that cost more than $500 for a 30-day supply; and 3) early refills where less than 75% of the original prescription has been used up. Section 52 of P.A. 03-2 describes the particulars of the plan.

Through Public Act 03-3, the Legislature enacted additional cost-containment requirements for state-funded pharmacy programs. **Section 82** required pharmacists to fill prescriptions for Medicaid, ConnPACE and SAGA recipients using the most cost-effective dosage feasible that is consistent with the prescription. **Section 84** clarified this**,** however, indicating that where a brand-name drug is less expensive than a generic (by reason of supplemental rebate on the brand-name), the pharmacist must fill with the brand-name drug.

Advocates have expressed ongoing concern about prior authorization. An essential component of a workable prescription assistance program is access to the benefit. Adopting cost-saving policies that compromise this access is dangerous for several reasons. First, many participants of the ConnPACE program in need of drug fills and re-fills are ill-equipped by reason of 1) lack of reliable and affordable transportation; 2) age-related frailty; 3) physical disability; and 4) low literacy levels to seek and wait out an initial administrative review period, much less a second such review if the initially prescribed drug must be replaced due to inefficacy or an adverse reaction. Second, the current procedure imposes unworkable requirements on already busy pharmacists to place calls requesting prior authorization to both the call center and to the involved physician. Third, these policies disproportionately affect qualified program participants, and not those companies from which DSS purchases drugs. From a policy standpoint, it is inequitable that these low-income individuals should bear the consequences of ever-increasing drug costs, over which they have no control. Finally, these policies are shortsighted. If individuals are forced because of administrative delays or failure of the administrative process to go without needed medication, the risk of need for much costlier medical care, up to and including hospitalization, increases. Ready access to financial assistance with purchase of appropriately prescribed, necessary drugs is,

therefore, an investment in forestalling state expenditures in other care settings.
As a counterpoint to the above, there have been some efforts to address drug costs at a systemic level. **P.A. 04-101** charges DSS with evaluating the feasibility, safety and cost-effectiveness of reimporting prescription drugs from Canada, and waiving ConnPACE co-payments for such drugs.

Expansion of Preferred Drug List

Related to the prior authorization requirements is that **Section 8 of Public Act 04-258** expands the previously enacted preferred drug list (essentially, a restrictive formulary) to nearly all classes of drugs under the Medicaid, ConnPACE and SAGA programs (exemptions are made for mental health and antiretroviral drugs) – effective July 1, 2004.

Preferred Drug List Background

Section 83 of Public Act 03-3 invoked the previously enacted requirement that DSS adopt a preferred drug list for the Medicaid and ConnPACE programs for three classes of drugs (proton pump inhibitors and two additional classes to be identified by DSS). In the 2004 session, this list was expanded to all classes of drugs other than mental health and anti-retrovirals.

II. Access to Home and Community-Based Services

Over the past five years, the Administration and the Legislature have made steady progress in enhancing Connecticut's commitment to affordable home and community-based services. Examples of this commitment include:

1) expansion of the service array of the Connecticut Home Care Program for Elders (CHCPE) to include a pilot that permits 50 individuals statewide to hire, train and flexibly manage a personal care assistant;
2) creation of alternate methods by which CHCPE services can be received, including permitting residents of state-funded congregate buildings to receive their program service through an on-site assisted living agency and a pilot that permits a certain number of residents of managed residential care buildings who have exhausted their financial resources to have their services (but not room and board) paid through the program; and
3) authorization for free-standing, new construction affordable assisted living buildings (sites in Glastonbury and Hartford will be opening in 2004).

- **CEAN Priority Statement**: Secure State support of the principle that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting.

Principle of Choice and Least Restrictive Setting in Long-Term Care Options

In the 2004 session, the Long Term Care Advisory Council sought to amend the enabling statutes that created the Long Term Care Planning Committee by adding the following policy statement:

"Such policy and plan shall provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting."

Regrettably, there was no action on the bill that contained this policy statement prior to committee deadline, and it was not successfully appended to another bill prior to the end of the session.

Background of Statement of Principle/Facilitation of Choice in Long-Term Care

The Long-Term Care Advisory Council proposed to amend Section 501, Subsection (a) of C.G.S. 17b-337, which established the Long-Term Care Planning Committee, with a guideline principle to be considered when coordinating policy development and implementing the recently released Long Term Care Plan. The guideline principle is consistent both with the Supreme Court's 1999 decision in Olmstead, which addressed claims of institutionalized individuals under the federal Americans with Disabilities Act, and with the expansion in 2001 of the statutory scope of authority of the Long Term Care Planning Committee to include all people in need of long-term care, not simply older adults.

Separately, the Legislature also considered a bill concerning duties of conservators in making long-term care choices for their wards. Unfortunately, Senate Bill 3, which proposed 1) that prior to placing a ward in a nursing facility, conservators submit to the probate court a report documenting the basis for this decision, identifying community-based alternatives that were considered, and reasons for which the ward cannot be served in a less restrictive setting; and 2) to provide for a hearing to address the suitability of the placement, was not acted on prior to the end of the session.

Related to choice of long-term care setting are pending efforts on the part of the State to make rule changes in the Medicaid program designed to require individuals to spend private resources for care in lieu of principally relying on Medicaid support. A key example of this is that the State has sought a federal waiver for purposes of establishing that a penalty period for transfer of assets for less than fair market value begin in the month in which the applicant is otherwise eligible for Medicaid coverage of services (as opposed to the date on which the transfer occurred); and further, that the look-back period for real estate transfers be changed from 3 to 5 years. This waiver application has been pending review at the federal Centers for Medicare and Medicaid Services (CMS) for one and a half years and has not yet been acted upon.

Other elements of the State's efforts to reduce Medicaid payments for long-term care include: a) Section 62 of Public Act 03-3, which among other provision created transferee liability (obligation to reimburse the State) where adult children or others have received assets from individuals applying for Medicaid (presumed to be contingent on approval of the transfer of assets waiver); and b) Section 63, which adopts an "income first" rule where additional funds are needed to make up the community spouse minimum monthly needs allowance. Also of note was an effort on the part of the Senate Democrats to establish a task force on long-term care funding to study such options as requiring family contributions. This yielded Raised Bill 606, which was not acted on prior to the end of the session.

Unfortunately, bills that sought 1) to change waiver approval procedure; and 2) compel the DSS Commissioner to withdraw the pending transfer of assets waiver proposal, died in committee in the 2004 session. Further, Sections 62 (transferee liability, transfer of assets waiver "companion" provisions) and 63 ("income first" rule) of P.A. 03-3 (the '03 DSS Implementer) were not repealed in 2004.

Of note is new authorization through Section 4 of Public Act 04-258 for an acute care managed care pilot serving no more than 500 individuals dually eligible for Medicare and

Medicaid – effective upon passage (May 21, 2004)
A final element of choice is preserving access to state-funded programs for legal immigrants. Sections 15-18 of Public Act 04-258 reopen state-funded programs including SAGA, state-funded medical assistance, the Home Care Program and Food Stamps to legal immigrants – effective July 1, 2004.

- **CEAN Priority Statement:** Expand enrollment for the Personal Care Assistance Pilot Program (also known as Elder Pilot) for those 65 years and older.

- **CEAN Priority Statement:** Support proposals to expand enrollment the Personal Care Assistant Waiver for people age 18-64 years of age (contingent upon federal approval) from 498 individuals to 700.

Creation of New Personal Care Assistance Pilot Program

Sections 40 and 41 of Public Act 04-258 1) create a new personal care assistant pilot under the Home Care Program that will serve up to 100 seniors and permit relatives other than spouses to serve as personal care assistants; and 2) require DSS to apply for a federal waiver to include the pilot services in the Medicaid component of the Home Care Program – effective July 1, 2004. This pilot is over and above the existing Personal Care Assistant Pilot that currently serves up to 50 individuals statewide.

Background of Personal Care Assistance Initiatives

Historically, younger individuals with disabilities in need of personal care support successfully sought authorization to hire and manage their own helpers. Through Medicaid funding, this Personal Care Assistance Waiver (PCA Waiver) program serves Connecticut residents age 18-64, who are permanently and severely disabled and capable of hiring, supervising and directing a personal care assistant. Personal care assistants (PCA's) may provide assistance with activities of daily living, such as eating, bathing, dressing and grooming. Additionally, PCA's may provide help with taking medicine, meal preparation, housekeeping, errands, laundry, assistance with personal financial transactions and transportation. In 2004, a PCA applicant may have no more than $1,692 in income and $1,600 in assets.

Over time, advocates became concerned that as certain participants of the PCA Waiver were aging out of eligibility for the program (Waiver serves individuals through age 64, Connecticut Home Care Program for Elders serves individuals 65 and older), there was no mechanism under the Connecticut Home Care Program for Elders (CHCPE) to allow them to continue to employ their personal care assistants, many of whom had been working in this capacity for years. Further, Access Agencies of the CHCPE began to express concerns about certain clients of the program for whom traditional, home-health based care plans were not achievable due to changeable individual needs.

In response to both of these constraints, a small state-funded Personal Care Assistance pilot (PCA Pilot) program was established in 2000 to serve up to 50 individuals statewide who are age 65 or older and meet all of the technical, functional and financial eligibility requirements of the CHCPE. This program is available to (1) individuals who have previously received services under the PCA Waiver; and (2) individuals who are unable to access adequate home care services to remain in the community. The PCA Pilot allows eligible individuals to hire a PCA to perform up to 25.75 hours of assistance per week. The

only limitation on hiring of a PCA is that the individual's spouse, power of attorney or conservator (and their employees), are not eligible. Individuals must be referred for consideration for this pilot by the Access Agency through which their services are received.

After three years of operation, it became apparent that the 50 slots available under the PCA Pilot would not accommodate the needs of all individuals aging out of eligibility for the PCA Waiver. Further, based on program evaluation that showed the Pilot to be modestly cost-effective and strongly preferred as a service mechanism by participants, advocates urged the Legislature to make PCA's a covered service of the CHCPE. This would permit use of PCA's in appropriate circumstances as an alternate to traditional care plans, and further DSS's goal of serving additional clients through "self-direct" models. As a result of ongoing debate, PCA's were not included as a covered service of the CHCPE in the 2004 session, but the additional pilot described above was enacted as a means to serve additional clients.

- **CEAN Priority Statement:** Support the important work of the Nursing Facilities Transition Grant (supported for the last three years by federal funding and soon to expire), by funding the project for an additional three-year period utilizing state funds at a cost of $800,000.

Nursing Home Facilities Transition Grant

The Legislature appropriated $267,000 in support of continuing the efforts of the Nursing Home Facilities Transition Grant, federal funding for which will expire in September, 2004.

Background on Nursing Home Facilities Transition Grant

Initially funded through a federal grant, the State of Connecticut successfully launched the Nursing Facility Transition Grant to assist individuals with disabilities in accessing home and community-based services and supports in lieu of residing in institutions. Elements of this program include use of Section 8 housing vouchers, subsidy for re-location and home modifications (as needed), and ongoing support.

- **CEAN Priority Statement:** Provide additional State support for demand transportation (for example Dial-A-Ride).

Transportation

House Bill 5006 proposed to appropriate $500,000 in funding for the Dial-a-Ride program, but there was no action on this bill prior to committee deadline.

Background on Transportation

In its *Preliminary Long-Term Care Plan*, Connecticut's Long-Term Care Committee recognized that expanded transportation services are integral supports that allow older adults and younger disabled individuals to live successfully in the community. In its *Elderly Transportation Services* report [December 1998], the Legislative Program Review and Investigation Committee (LPRI) concluded that:

- *no state agency has responsibility for program oversight because there is no state mandate for dial-a-ride programs for the elderly;*
- *no single funding source exists, instead funding is a patchwork of federal, state and local monies; and*
- *multiple delivery models exist, making identification of programs problematic.*

Despite the recommendations presented in this report, the Legislature has subsequently been challenged by limited funding and structural issues in achieving coordination and increased funding for paratransit serving older riders. In 1999, the Legislature did authorize the Commissioner of Transportation to create a municipal grant program to assist in making support for transit programs more accessible and equitable. In 2000, the Legislature revisited the program, imposing new requirements through which transit districts would be required to apply for funds through regional planning agencies. Compromising the goal of the law, however, was that no new funds were appropriated in support of the program. Failure to fund and implement the municipal grant program has placed additional burdens on municipalities.

- **CEAN Priority Statement:** Oppose co-pays for non-emergency medical transportation for Medicaid and SAGA recipients.

No Medical Transportation Co-Pays

The Legislature did not authorize co-payments for Medicaid and SAGA-funded medical transportation.

Medicaid/SAGA Medical Transportation Co-Pay Background

Section 11 of House Bill 5041 (part of the Governor's budget proposals) sought to establish a $2 co-payment for each non-emergency ride for those not enrolled in managed care plans. This was not made part of the approved State budget.

- **CEAN Priority Statement:** Support adequate funding for towns and municipalities to provide critical services to older adults.

- **CEAN Priority Statement:** Support utilizing a portion of the ConnPACE cost-savings derived from the new Medicare prescription drug program to provide State funding for the first time for the CHOICES program.

State Support for Municipal Efforts on Behalf of Elders/CHOICES Program

Overall, state support for municipalities was increased in 2004 from the dramatic reductions made necessary by deficit in the 2003 session. Notwithstanding, there remains substantial concern among advocates that local funding for elderly services continues to be inadequate to meet increasing demand that has been created by demographic trends, slow economic recovery, and reduced staffing at the regional offices of DSS.

Background on State Support for Municipal Efforts/CHOICES Program

On a local level, a significant array of supports is provided to elders through senior centers and municipal agents for the elderly. Often, this staff is regarded as the immediate hub point of information on benefits such as prescription drug assistance, tax relief, income supports and meals. Over the last several years, it has become increasingly difficult to maintain adequate capacity to meet demand as social services funding and departments have been consolidated and/or reduced.

Connecticut's program for **H**ealth **I**nsurance **A**ssistance, **O**utreach, **I**nformation & Assistance, **C**ounseling, and **E**ligibility **S**creening (**CHOICES**) is a multi-faceted initiative among the five Connecticut Area Agencies on Aging (AAA), the Department of Social Services Elderly Services Division and the Center for Medicare Advocacy. CHOICES connects older consumers and their caregivers with clear and unbiased resource information on a broad range of topics including Medicare, Medicare supplement insurance (Medigap), Medicaid, Connecticut Partnership for Long Term Care policies, entitlements and community-based services. CHOICES also provides older adults and others with a meaningful volunteer opportunity to be trained as counselors in the community; and ensures that elderly services professionals have a reliable and current source of training and materials to help them optimally serve their clients. Despite ongoing growth and dramatically increased demand for the program due to questions concerning the new Medicare Prescription Drug Discount Card Program, the State has not historically provided funding to CHOICES.

III. Access to Information and Services

CEAN operates on an expansive definition of advocacy that is not limited to legislative action. Reflective of this is its position statement expressing concern about the impact of State workforce reductions and closure and consolidation of certain of the Department of Social Services (DSS) regional offices.

- **CEAN Priority Statement:** Direct DSS to report to the Legislature on the impact of the closure and consolidation of the regional offices and the workforce reductions on recipients, confirming that commitments made by the Commissioner to provide alternate application and re-determination procedures for those with impairments are implemented.

Update on Closure and Consolidation of Department of Social Services Regional Offices

A recently released DSS memo notes that effective June 22nd, clients of DSS programs who reside in Meriden will be served by the Middletown office. This changed the existing requirement that those clients be served through the New Haven regional office.

Recipients of food stamp and Medicaid assistance have continued to receive notices informing them that they are required to appear in person at the regional office for semi-annual redetermination of their eligibility for benefits, notwithstanding the fact that they are homebound, frail or disabled.

Background on Closure and Consolidation of DSS Regional Offices

Due to State budget constraints in 2003, DSS was required to make sweeping reductions in its overall workforce. Between layoffs and election of early retirement, the DSS staff was reduced by an overwhelming 21%. This has seriously compromised the department's capacity to respond to the current level of need among the populations it serves.

Additionally, several of DSS's sub-region offices (Norwich, Meriden) were closed and clients were notified that they would instead be served by hub regional offices (e.g. New Haven). Further, DSS announced re-organization of its service area map to include three super-regions in lieu of the five previously observed regions.

Responding to concerns of advocates that many recipients would face significant barriers to getting to the hub offices (due to inadequate transportation or disability), in testimony before the Human Services Committee of the Legislature, the DSS Commissioner announced that the Department would develop protocols to enable such individuals to be re-determined for benefits over the telephone (in lieu of requiring an office visit).

IV. Other Bills of Interest

Favorable Action

Entitlements

- **Unemployment Compensation:** Section 3 of Public Act 04-214 eliminates the unemployment compensation benefit reduction for individuals receiving Social Security – effective from passage.

Nursing Home Issues

- **Patient's Bill of Rights/Authority of Ombudsman:** Public Act 04-158 strengthens the patient's bill of rights and authorizes a pilot, within available appropriations, through which the Long Term Care Ombudsman can provide assistance and education to residents of certain managed residential communities (MRC's) and state-funded congregate housing sites at which services are provided by an assisted living services agency.

Staffing

- **Long Term Care Workforce Shortages:** Public Act 04-196 appropriates funding to the Department of Higher Education to permit it to make grants to community-technical colleges in support of faculty enhancement, establishes a nursing faculty incentive program with other college programs that work with hospitals, and charges it with conducting a needs assessment of capacity to educate and train nurses. *See also:* Public Acts 04-220 and 04-253

Not Enacted

Elder Abuse

- **Background Checks:** bills that sought to mandate criminal background checks on direct care staff and volunteers in nursing homes and home care agencies died in committee.

- **Elder Death Review Team:** a bill that proposed to require that the Office of the State Medical Examiner establish an interagency elder death review team to assess deaths potentially attributable to elder abuse or neglect died in committee.

Entitlements

- **State Supplement:** bills that proposed to allow recipients of State Supplement to receive cost-of-living increases in Supplemental Security Income without corresponding decreases in their State Supplement payment died in committee.

Grandparents Raising Grandchildren

- **Subsidies:** bills that proposed 1) to require that DCF permit relative caregivers whose income is less than 300% of the FPL and who have been appointed guardian or co-guardian of a child because the parent a) has died; or b) is terminally ill, to qualify for subsidized guardianship; 2) that DSS establish a "Grandparents as Parents" program; and 3) to provide a rental assistance program for relative caregivers, died in committee.

Housing

- **Resident Issues in Subsidized Housing:** bills concerning 1) studies of housing needs; 2) social services supports for older adults and individuals with disabilities living in subsidized housing; and 3) role and responsibilities of resident service coordinators died in committee or were not acted upon before the end of the session. The Legislative Program Review and Investigations Committee will be conducting a study on certain of these issues.

Long Term Care

- **Statewide Needs Assessment:** the section of the Long Term Care Advisory Council-sponsored bill that proposed to appropriate funds in support of a statewide assessment of long term care needs was not acted upon before the end of the session.

Medicare

- **MediGap Protections:** bills that sought to 1) prohibit Medicare supplement insurers from raising Medigap policy rates for six months from the date on which a policy is issued; 2) require Medicare supplement insurers to offer their products to all Medicare recipients, including those eligible by reason of disability; and 3) extend group health insurance for individuals age 55 and over until they become eligible for Social Security died in committee.

- **Dual-Eligibles:** a bill that sought to require DSS to fully reimburse medical providers that serve those dually-eligible for Medicare and Medicaid died in committee.

Nursing Home Issues

- **Staffing Levels:** a bill that sought to 1) increase direct care provider staffing levels to require one full-time employee for each ten residents during the day shift, one full-time employee for each fifteen residents during the evening shift, and one full-time employee for each twenty residents during the night shift, and to improve these ratios over time; 2) require homes to report failure to meet standards; and 3) give DPH the option to take action against homes for failure to report staffing deficiencies, was not acted on before the end of the session.

- **Provider Tax:** an effort to impose a per diem tax on nursing facilities and then reciprocally increase Medicaid reimbursement (essentially a mode of rate relief for homes with high percentages of residents on Medicaid) was not acted on before the end of the session.

- **Medication Administration:** bills that sought to require facilities to develop and implement pain management protocols and to establish a medication technician pilot program for nurse's aides were not acted upon prior to the end of the session.

Taxes

- **Various:** bills that proposed to 1) create an income tax deduction for long-term care expenses relating to care of an older adult by an immediate relative in the relative's home; 2) create an income tax deduction for purchase of long-term care insurance; 3) to allow income tax deduction for up to $50,000 in nursing home expenses per year, 4) to create income tax deduction for donation of organ; 5) create income tax exemption on proceeds from sale of stocks/bonds used for nursing home payment; and 6) create income tax credit for certain amounts paid for long-term care insurance all died in committee. A bill that proposed decoupling of federal and State estate taxes, was not acted upon prior to the end of the session.

V. Conclusion

The 2004 Legislative Session in Connecticut represented welcome partnership among legislators, advocates and citizens. Facilitated by an improved assessment of Connecticut's financial situation, legislators recognized the need to revisit many of the cost-containment provisions of the 2003 budget. Notable examples of these of concern to older adults include the Medicaid co-payments and the ConnPACE asset test and estate recovery provisions. Further, the Legislature provided substantial guidance on how the ConnPACE program will interact with the Medicare Prescription Drug Discount Card program, as took action to preserve the current level of ConnPACE benefits.

Despite significant commitment on the part of the State to the concept and practice of home and community-based care, however, the level of public resources devoted to institutional care still remains disproportionate to that expended for home care supports. This issue clearly warrants additional efforts to work through the complex allocation of funds, personnel and infrastructure that is involved. Further, the trend toward emphasizing personal responsibility in payment for long-term care should be tempered by tax and workplace incentives to do so, and policy makers must be vigilant in preserving access to support for those in legitimate need.

A special thanks to Kate McEvoy for drafting this report on CEAN's behalf.

For more information on becoming involved with CEAN, please contact the CT Commission on Aging, the lead agency for CEAN.

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